Print Reset

STATE OF MISSOURI
DEPARTMENT OF INSURANCE, FINANCIAL & PROFESSIONAL REGULATION

CERTIFICATE OF REGISTRATION APPLICATION FOR UTILIZATION REVIEW AGENTS

☐ NEW APPLICATION
☐ RENEWAL APPLICATION

FOR THE REGISTRATION PERIOD | **NAIC COCODE/GROUP (if applicable)**

THIS APPLICATION FOR CERTIFICATION AS A UTILIZATION REVIEW AGENT IS MADE BY:

1. NAME | FEIN

2. THE APPLICANT IS THE FOLLOWING TYPE OF BUSINESS ENTITY CHECK ONLY ONE (1) ENTITY:
☐ INDIVIDUAL ☐ PARTNERSHIP ☐ CORPORATION ☐ LLC ☐ OTHER

3. BUSINESS STREET ADDRESS (STREET, CITY, STATE, ZIP CODE) (DO NOT USE A POST OFFICE BOX)

4. BUSINESS MAILING ADDRESS (STREET OR POST OFFICE BOX, CITY, STATE, ZIP CODE) | EMAIL OF CONTACT

5. BUSINESS TELEPHONE NUMBER ( ) | COMPANY WEBSITE

6. IF APPLICANT IS A CORPORATION, PROVIDE THE STATE OF INCORPORATION

7. PLEASE LIST ANY OTHER LICENSES ISSUED BY DIFP

8. LIST ALL OTHER LOCATIONS, PROVIDING COMPLETE ADDRESSES AND TELEPHONE NUMBERS. (ATTACH A SEPARATE SHEET TO THE APPLICATION IF NECESSARY)

ADDRESS (P.O. BOX, STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER

9. **PROVIDE THE NAMES AND RESIDENTIAL ADDRESSES OF ALL OFFICERS, DIRECTORS AND PARTNERS**

NAME	RESIDENTIAL ADDRESS

10. **NAME, ADDRESS, AND PROFESSIONAL MEDICAL LICENSE NUMBER OF YOUR MISSOURI LICENSED MEDICAL DIRECTOR** (376-1361 RSMo.)

NAME	ADDRESS	MISSOURI LICENSE #

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11. Has the applicant, or any one (1) of its incorporators, owners, partners, officers, directors or employees performing utilization reviews had any of the following, in this state or any other state, since the last anniversary date of the original certification:

Yes	No	
☐	☐	an application for a utilization review agent license or similar license denied, revoked, or suspended
☐	☐	paid a fine or forfeiture in connection with such license
☐	☐	had any professional, vocational or business license denied, suspended or revoked by any public authority

If the answer to any item is yes, then attach a complete explanation.

12. Attach a cashiers check or money order made payable to the Missouri Department of Insurance in the total amount of one thousand dollar ($1000). Hereafter, the annual registration fee of five hundred dollars ($500) is due not later than the anniversary date of the original certification.

13. The applicant, being first duly sworn, states that s/he has completed this application or that s/he has read the application and knows its contents and its attachments. That to the best of his/her knowledge and belief the statement made upon this application and upon all attachments are true, correct and complete in every material respect. Do not contain any statement which, under the circumstances in which it was made, would be false or misleading in respect to any material fact. That s/he has read and understands the laws of the state of Missouri pertaining to utilization review and utilization review agents. The applicant further certifies, under oath, that it complies with all laws regulating Utilization Review Agents, including Sections 374.510 and 376.1350 - 376-1390, RSMo.

IF THE APPLICANT IS A **INDIVIDUAL**	INDIVIDUAL SIGNATURE ☒ TYPE INDIVIDUAL NAME
IF THE APPLICANT IS A **PARTNERSHIP**	PARTNER SIGNATURE ☒ TYPE MANAGING GENERAL PARTNER NAME
IF THE APPLICANT IS AN **CORPORATION/LLC**	OFFICER SIGNATURE ☒ TYPE OFFICER NAME AND TITLE

NOTARY PUBLIC

NOTARY PUBLIC EMBOSSER SEAL	STATE OF		COUNTY
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF		
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	USE RUBBER STAMP IN CLEAR AREA BELOW
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		

14. MAIL THIS COMPLETED APPLICATION TO:

MISSOURI DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
MANAGED CARE SECTION ATTN: UR AGENTS
PO BOX 4001
JEFFERSON CITY, MO 65102

STATE OF MISSOURI
DEPARTMENT OF INSURANCE, FINANCIAL & PROFESSIONAL REGULATION

CLIENT INFORMATION
FOR UTILIZATION REVIEW AGENTS

	CLIENT NAME	COMPLETE ADDRESS	PHONE NUMBER	CONTACT NAME	CONTACT EMAIL ADDRESS
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					